CALIFORNIA CODE OF REGULATIONS
TITLE 10. INVESTMENT
CHAPTER 5. INSURANCE COMMISSIONER
SUBCHAPTER 2. POLICY FORMS AND OTHER DOCUMENTS
ARTICLE 6. ~~EXCLUSIVE NETWORK PROVIDER PROVISIONS IN GROUP~~ PROVIDER NETWORK ACCESS STANDARDS FOR DISABILITY POLICIES AND AGREEMENTS

Proposed changes to the regulation are shown as follows:

1) Changes proposed in the November 2006 notice are shown in ~~single strikethough~~ and single underline;

2) Changes proposed in the September 2007 15-day notice are shown in ~~double strikethough~~ and double underline

3) Changes proposed in the October 2007 15-day notice are shown in ~~**bold double strikethough**~~ and **bold double underline**

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§ 2240. Definitions.

As used in this Article:

(a) "Basic health care services" means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory, diagnostic and therapeutic radiology~~ic~~ services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance services.

(7) Mental health care services including those intended to meet the requirements of Insurance Code 10144.5.

(8) Any other health care or supportive services that are covered ~~issued~~ pursuant to an insurance ~~group~~ contract.

(b) "Certificate" means an individual or family certificate of coverage issued pursuant to ~~a group~~ an insurance contract.

(c) "Covered person" means either a primary covered person or a dependent covered person eligible to receive basic health care services under the insurance contract providing network provider services.

(d) "Dependent covered person" means someone who is eligible for coverage under an ~~group~~ insurance contract through his or her relationship with or dependency upon a primary covered person.

(e) "Emergency health care services" means health care services rendered for any condition in which the covered person is in danger of loss of life or serious injury or illness or is experiencing severe pain and suffering.

(f) " ~~Exclusive~~ Network provider" means an institution or a health care professional which renders ~~exclusive provider~~ health care services to covered persons ~~under a group contract~~ pursuant to a contract ~~with the insurer~~ to provide such services at alternative rates.

(g) "~~Exclusive~~ Network provider services" means health care services which are covered under an insurance ~~fl~~group contract ~~only~~ when rendered by a~~n~~ ~~exclusive~~ network provider within the service area.

(h) "Non-network provider services" means covered health care services delivered by a health care provider who is not contracted with the insurer either directly or indirectly.

~~(h) "Group contract" means a master group disability insurance policy or master group hospital service agreement containing provisions covering exclusive provider services.~~

(i) "Health care professional" means a licensee or certificate holder enumerated in Insurance Code 10176 as of the effective date of this Article or as that Section may be amended thereafter.

(j) "Insurer" means an insurer ~~or nonprofit hospital service plan~~ who provides 'health insurance" as defined in Section 106 (b), and includes those who authorize insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133.

~~k)"Material Modification" means those changes that a reasonable covered person would consider important regarding gaining timely access to appropriate health care.~~

~~(k)~~ ~~(l)~~ (k) "Primary care physician" means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

~~(l)~~ ~~(m)~~ (l) "Primary covered person" means a person eligible for coverage under ~~a group contract because of his or her membership in a group~~ an insurance contract or certificate.

~~(m)~~ ~~(n)~~ (m)"Service area" means ~~a~~ the State of California or any other geographic~~al~~ area **within the state** designated in the contract within which ~~exclusive~~ network provider services are rendered to covered persons **for covered benefits.** ~~.~~ ~~**or covered services are available for some level of coverage under the insurance contract.**~~

~~(m)~~ ~~(o)~~ (n) "Network" means all institutions or health care professionals that are utilized to provide medical services to covered persons pursuant to a contract with an insurer to provide such services at alternative rates as described in Insurance Code Section 10133. A network as defined herein can be directly contracted with by an insurer or leased by an insurer.

Note: Authority cited: Section 10133.~~3~~5, Insurance Code. Reference: Sections 10133, 10133.5 ~~and 11512~~, Insurance Code.

§ 2240.1. Adequacy and Accessibility of ~~Exclusive~~ Provider Services.

(a) The provisions of this article apply to "health insurance" policies as defined by Insurance Code section 106(b). Notwithstanding the above, the provisions of this article do not apply to supplemental policies of health insurance that provide coverage for vision care expenses only or dental care expenses only.

~~(a)~~ (b) In arranging for ~~exclusive~~ network provider services, insurers shall ensure that:

(1) ~~Exclusive~~ Network providers are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the ~~exclusive~~ ~~provider~~ health care services covered by the ~~group~~ insurance contract, taking into account the number of covered persons, their ~~special~~ characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outline~~s~~d herein and the projected demand for services by type of services.

(2) Decisions pertaining to health care services to be rendered by ~~exclusive~~ providers to ~~individual~~ covered persons are based on such persons' medical needs and are made by or under the supervision of licensed ~~physicians or other~~ and appropriate health care professionals.

(3) Facilities used by ~~exclusive~~ providers to render basic health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible to the physically handicapped.

(4) Basic health care services (excluding emergency health care services) ~~covered as exclusive provider services~~ are available at least 40 hours per week, except for

weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.

(5) Emergency health care services are available and accessible within the service area at all times.

~~**(6) The ratios of covered persons to health care professional staff members (directly or through referrals), and to administrative and other supporting staff members of institutional exclusive providers are such that it can be reasonably expected that all exclusive provider services will be accessible to covered persons without delays detrimental to the health of each the covered persons.**~~

(~~**7**~~ **6**) ~~**Health care professionals** who may legally render the services covered as exclusive provider services~~ **Basic health care services** are accessible to covered persons through **network providers, or other network arrangement** ~~**staffing, contracting or referral**~~. ~~This shall not be construed to allow a covered person to select or obtain such services from a certificate or license holder who has not contracted with the insurer to provide such services at alternative rates.~~

(~~**8**~~ 7) ~~Exclusive~~ Network ~~P~~provider services are rendered pursuant to written procedures which include a documented system for monitoring and evaluating accessibility of such ~~of~~ care. The monitoring of waiting time for appointments shall be a part of such a system.

~~(b)~~ (c) In arranging for ~~**physicians'**~~ **network** provider services ~~which shall be covered as exclusive provider services~~, insurers shall ensure that:

(1) There is the equivalent of at least one full-time physician ~~to~~ per ~~each~~ 1,200 covered persons and at least the equivalent of one full-time primary care physician ~~for each~~ per 2,000 covered persons.

(2) There ~~is~~ are primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace.

(3)There are ~~M~~medically required network specialists who are certified or eligible for certification by the appropriate specialty board ~~are accessible~~ with sufficient capacity to accept covered persons ~~through staffing, contracting or referral.~~ within 60 minutes or 30 miles of a covered person's residence or workplace. Notwithstanding the above, the Commissioner may determine that certain medical needs require network specialty care located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code 10133.5 (b) (3), support such modification.

(4) There are mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace.

(5) There is a network hospital with sufficient capacity to accept covered persons for ~~needed~~ covered services within 30 minutes or 15 miles of a covered person's residence or workplace.

(6) Notwithstanding the above, these requirements are not intended to prevent the covered person from selecting providers as allowed by their insurance contract beyond the applicable geographic area specified by these standards.

(7) If an insurer is unable to meet the network access standard(s) required by this section due to the absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver of any network access standard for the applicable geographic area. Such application should include, at a minimum, a description of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers.

~~(7) In any geographic area where no network provider is available to a covered person, and as a result the applicable network access standards cannot be met without using non-network providers, the insurer shall provide network benefits for on the same terms and conditions as covered persons receiving needed care from a non-network provider. This requirement shall continue until the insurer provides substantially similar health care services through network providers.~~

~~(8) If no providers described in these geographic access standards are practicing or available within the time or distance standards required by these regulations for any part of an insurer's service area. Those geographic access standards that cannot be physically met, shall not apply as to those covered persons residing or working within the portion of the service area that is out of compliance with these regulations due to physical impossibility.~~

~~(c)~~ (d) In determining whether an insurer's arrangements for ~~exclusive~~ network provider services comply with ~~the foregoing requirements~~ these regulations, the Commissioner shall consider to the extent ~~he~~ the Commissioner deems necessary, the practices of comparable health care service plans licensed under the Knox-Keene ~~Law,~~ Health Care Service Plan Act of 1975 Health and Safety Code Section 1340, *et seq*.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 ~~and 11512~~, Insurance Code.

§ 2240.2. Insurance Contract Provisions ~~of Group Contracts~~.

~~Group~~ Insurance contracts containing provisions covering ~~exclusive~~ network provider services ~~shall comply with all applicable statutes and regulations and~~ shall ~~also~~ contain the following:

(a) A provision for coverage on an indemnity or provision of service basis for emergency health care services rendered to covered persons outside the service area.

(b) A provision that the insurer shall give~~n~~ written notice to the contract holder, within a reasonable period of time, of any termination or permanent breach of contract by, or permanent inability to perform of, any ~~exclusive~~ network provider if such termination, breach or inability would materially and adversely affect the ~~group~~ contract holder or covered persons.

(c) A provision that the ~~group~~ contract holder shall distribute to the primary covered persons the substance of any notice given to the ~~group~~ contract holder pursuant to subsection (b) not later than 30 days after its receipt.

(d) A provision that, pursuant to Insurance Code Section 10133.56, upon termination of a~~n exclusive~~ network provider contract, the insurer shall be liable for covered services rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the ~~group~~ insurance contract.

(e) A provision defining the service area.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5, and 10133.56 ~~and 11512~~, Insurance Code.

§ 2240.3. Provisions of Certificates.

Certificates containing provisions covering ~~exclusive~~ network provider services ~~shall comply with all applicable statutes and regulations and~~ shall ~~also~~ contain the following:

(a) A description of the coverage provided by the ~~group~~ contract for emergency health care services rendered to covered persons outside the service area.

(b) A description of the coverage, if any, provided by the ~~group~~ contract for dependent covered persons who both live outside the service area and away from the principal residence of the primary covered person.

(c) A brief and prominent warning reflecting the limitations in the ~~group~~ contract pertaining to ~~exclusive~~ network provider services. Such warning shall identify, by caption or number, the certificate provisions required by subsections (d), ~~and~~ (e), and (f), below.

(1) Where the ~~group~~ contract provides coverage outside the service area, the warning shall be in bold-face type or set off by other means from the surrounding text, and shall ~~be to the effect that no benefits are payable for services received in the service area if not rendered by exclusive providers.~~ clearly specify the differences in coverage between network and non-network services in and out of the service area.

(2) Where the ~~group~~ contract provides no coverage (except for emergency health care services) outside the service area, the warning shall ~~state~~ include the warning required in (1) above, and shall additionally warn that no coverage is provided outside the service area, except for emergency health care services. The additional warning shall be ~~in red print~~ in a point size at least twice that used in the body of the certificate (excluding captions).

(d) **If applicable, a** ~~A~~ provision defining the service area wherein coverage is restricted to services provided by ~~exclusive~~ network providers.

(e) A provision or attachment ~~specifying the principal institutional exclusive providers~~ identifying all network providers or describing where a current directory of network providers can be found on the Internet.

~~(f) A provision or attachment specifying the principal professional exclusive providers or informing the certificate holder of how s/he may obtain rosters of professional exclusive providers.~~

(f) A prominent disclosure pursuant to Insurance Code Section 510 stating that covered persons who have complaints regarding their ability to access needed health care in a timely manner may complain to the insurer and to the California Department of Insurance. The disclosure shall include the address and the customer services telephone number of the insurer and the name address and toll free telephone number of the Consumer Services Division of the Department of Insurance

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 ~~and 11512~~, Insurance Code.

§ 2240.4. Contracts with Providers.

(a)Effective June 30, 2008, ~~C~~contracts between ~~exclusive~~ network providers and insurers or their agents shall: 1) be in writing and ~~shall~~ be fair and reasonable as to the parties to such contracts~~.~~ ; 2) ~~Such contracts shall~~ provide that ~~exclusive~~ network providers shall

not make any additional charges for rendering ~~exclusive provider~~ network services except as provided for in the ~~group~~ contract~~.~~ between the insurer and the insured; 3) ~~Such contracts shall~~ include all the agreements between the parties pertaining to the rendering of ~~exclusive~~ network provider services; 4) ~~and shall provide~~ recite that the provider's primary consideration shall be the quality of the health care services rendered to covered persons~~.~~; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on ~~any basis~~ the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, ~~handicap,~~ health status, health insurance coverage , utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 ~~and 11512~~, Insurance Code.
~~10 CA ADC s 2240.4~~

§ 2240.5 Filing and reporting requirements

(a)Whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver basic health care services, the insurer shall at the same time file with the Policy Approval Bureau of the California Department of Insurance:

~~(1) A full "GEOACCESS" or comparable annual report describing the number and location of all network providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations.~~

(1) A report describing the number and location of all network providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, such as a report produced using GeoAccess GeoNetworks® software offered by Ingenix Corporation.

(2) An affidavit or attestation acknowledging compliance with all the requirements of this regulation.

(3)A copy of written procedures required by Section 2240.1 (~~a~~ **b**) (~~8~~ 7).

(4) Complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health rehabilitation and ancillary service contracts. Rates or rate schedules need not be provided~~,~~ with this filing ~~however~~. All material changes to provider contracts must be filed with the Policy Approval Bureau as they become effective.

(b) Any insurer who by June 30, 2008 has not filed all of the information required by subsection (a) (1), (2), ~~and~~ (3), and (4) pertaining to each network of providers used for delivery of medical services under any policy of insurance in force, sold or offered for delivery in California shall do so for each such network by that date.

(c) An insurer seeking approval for a new product which will utilize a network that has previously been described to or filed with the department pursuant to subsections (a)(1) or (b), may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply with any of the provisions of this article. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the ratio~~n~~s required by Insurance Code Section 2240.1 (b) (1), (2), and (3) taking into account projected new covered lives.

(d) An insurer must notify the department immediately at any time that a material change to any of its networks results in the insurer being out of compliance with any of the provisions of these regulations and, at the same time**,** submit a corrective plan specifying all actions that the insurer is taking, or will take, to come into compliance with these provisions, and estimating the time required to do so.

(e) Health insurers that contract for alternative rates of payment with providers shall report annually to the Consumer Services Division of the Department of Insurance on complaints received by the insurer ~~**and providers**~~ regarding timely access to care. This report shall include a summary of receipt and resolution of complaints regarding access to or availability of any of the following services by type of service : ~~ancillary care, inpatient and outpatient hospital care, outpatient or hospital ambulatory surgery center services for limited English speakers, handicap access to any health care provider, emergency services, urgent care services, diagnostic services, mental health services, rehabilitation services, physical therapy, contracted network providers.~~ primary care services, specialty care services, mental health professional services and hospital services.

(f) The department shall review these complaint reports and any complaints received by the department regarding timely access to care and shall make this information public.

Note: Authority cited: Section 10133.5, Insurance Code Reference: Section 10133, 10133.5, ~~2240,2240.1~~ Insurance Code.